FOR OHF USE

LL1

2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0047373

Facility Name: Westchester Health & Rehabilitation

Address: 2901 South Wolf Road (Number) Westchester (City) 60154 (Zip Code)

County: Cook

Telephone Number: 708-531-1441 **Fax #** 708-409-1271

IDPA ID Number: 58-1398665001

Date of Initial License for Current Owners: 10/01/1989

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Lee Grigsby **Telephone Number:** 832-467-6244

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2005 to 12/31/2005 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Martha McDaniel
(Title) Reimbursement Manager

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Westchester Health & Rehabilitation # 0047373 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	120	Skilled (SNF)	120	43,800	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	120	TOTALS	120	43,800	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	21,811	8,980	7,686	38,477	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	21,811	8,980	7,686	38,477	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.85%

D. How many bed-hold days during this year were paid by the Department?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 10/01/1989

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 10/01/1989 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 120 and days of care provided 7,231

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2005 Fiscal Year: 12/31/2005

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Westchester Health & Rehabilitation # 0047373 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	236,467	24,674	280	261,421		261,421		261,421			1
2	Food Purchase		169,371		169,371	(41)	169,330		169,330			2
3	Housekeeping	115,950	14,336		130,286		130,286		130,286			3
4	Laundry	60,480	12,380		72,860		72,860		72,860			4
5	Heat and Other Utilities			156,419	156,419		156,419	66	156,485			5
6	Maintenance	75,024	68,056		143,080		143,080	259	143,339			6
7	Other (specify):* Waste/Garbage -See pg 3.1			27,018	27,018		27,018		27,018			7
8	TOTAL General Services	487,921	288,817	183,717	960,455	(41)	960,414	325	960,739			8
	B. Health Care and Programs											
9	Medical Director			14,469	14,469		14,469		14,469			9
10	Nursing and Medical Records	2,189,771	174,006	70,919	2,434,696		2,434,696	15,001	2,449,697			10
10a	Therapy	341,033	72,772	106,867	520,672		520,672		520,672			10a
11	Activities	67,714	4,119	9,397	81,230		81,230		81,230			11
12	Social Services	49,046			49,046		49,046		49,046			12
13	CNA Training											13
14	Program Transportation		10	60	70	(70)						14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,647,564	250,907	201,712	3,100,183	(70)	3,100,113	15,001	3,115,114			16
	C. General Administration											
17	Administrative	85,901			85,901		85,901		85,901			17
18	Directors Fees											18
19	Professional Services											19
20	Dues, Fees, Subscriptions & Promotions			77,639	77,639		77,639	(3,562)	74,077			20
21	Clerical & General Office Expenses	259,380	16,017	701,189	976,586		976,586	(313,049)	663,537			21
22	Employee Benefits & Payroll Taxes			679,600	679,600	41	679,641	(41)	679,600			22
23	Inservice Training & Education											23
24	Travel and Seminar			18,361	18,361		18,361	19,358	37,719			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			106,837	106,837		106,837		106,837			26
27	Other (specify):*											27
28	TOTAL General Administration	345,281	16,017	1,583,626	1,944,924	41	1,944,965	(297,294)	1,647,671			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,480,766	555,741	1,969,055	6,005,562	(70)	6,005,492	(281,968)	5,723,524			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

SUPPLEMENTAL SCHEDULE OF OTHER EXPENSES

Operating Expense - Line 7	Amount
Infectious Waste Disposal <> Default <> Nursing Admin/Supv	8,836
Infectious Waste Disposal <> Default <> Physical Plant	0
Garbage Service<>Default<>Prod<>Physical Plant	18,183
Garbage Service <> Default <> Physical Plant	0
	27,019

Health Care Program - Line 15	Amount
N/A	
	0

General & Adminstrative - Line 27	Amount
N/A	
	0

Inservice Education - Line 23 Column 3 (over $2,000)	Amount
N/A	
	0

STATE OF ILLINOIS

Facility Name & ID Number Westchester Health & Rehabilitation # 0047373 Ending: 12/31/2005

Meals - adjustment

38,477	Days (Total Patient days)
3	Mult (3 meals a day)
115431	Sub total
30	meals to employess (reported by facility)
115461	Add Sub
157,266	Divide -Pg 3, line 2, column 2
1.36	Cost per day

1.36	Cost per day
30	mult - meal to employees
41	= adjust for pg 2, line 2, column2

Sales Tax - adjustment

169,371	Total Food Cost (page 3,Line 2, col 3)
0.01	Mult
1693.71	Sub total
100.00%	Mult (Pvt pay div by total census)
1694	* I/2
847	= adjust for nonallowable sale tax

Reclassification V

Page 3 Line 14

Supplies<>Dept<>Non<>Default<>Prod<>Transport Non<>Emergency	8000000000003850	(10)	Reclass
Res/Client Transportation<>Default<>Prod<>Transport Non<>Emerge	810004000003850	(60)	Reclass
		(70)	Total

Page 4 Line 35 Rent

Lease Exp <> Vehicles<>Default<>Prod<>Transport Non<>Emergency	841005000008100		Reclass From
(194 x 70% = 135.80 lease for Medical)		(136)	
Page 4 line 38		136	Reclass to

Facility Name & ID Number Westchester Health & Rehabilitation #0047373 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			8,658	8,658		8,658		8,658			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			260,333	260,333		260,333	(20,061)	240,272			33
34	Rent-Facility & Grounds			747,434	747,434		747,434	(124,245)	623,189			34
35	Rent-Equipment & Vehicles			194	194		194	15,943	16,137			35
36	Other (specify):*							20,376	20,376			36
37	**TOTAL Ownership**			1,016,619	1,016,619		1,016,619	(107,987)	908,632			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation					70	70	(70)				38
39	Ancillary Service Centers			48,598	48,598		48,598	31,950	80,548			39
40	Barber and Beauty Shops			(200)	(200)		(200)	200				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			65,700	65,700		65,700		65,700			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			114,098	114,098	70	114,168	32,080	146,248			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,480,766	555,741	3,099,772	7,136,279		7,136,279	(357,875)	6,778,404			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Westchester Health & Rehabilitation # 0047373 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(41)	22		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(70)	38		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(191,897)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(564,402)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (756,410)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	398,537		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 398,537		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (357,873)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.	X		$ 70	14	38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$ 70		47

Westchester Health & Rehabilitation

ID# 0047373

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Sales Taxes	$ (612)	21	1
2	Small Balance Adjustment		21	2
3	Memorium/ Benevolance	(102)	21	3
4	Depreciation Reconciliation		30	4
5	Activities Program Receipts		11	5
6	Property Tax Adjust to actual	(21,694)	33	6
7	Professional liability Insurance		26	7
8	Barber & beauty	200	40	8
9	Public Relations Expenses		20	9
10	Non Allowable Advertising	(4,909)	20	10
11	Entertaiment	(17)	24	11
12	Fresh Start		36	12
13	Civic Dues		20	13
14	Penalities		21	14
15	Vending reciepts	(398)	21	15
16	Misc Reciepts	(4,268)	21	16
17	Marketing Wages 70% Disallowed	(33,094)	21	17
18	Marketing Bonus 70% Disallowed		21	18
19	Marketing Holiday 70% Disallowed	(866)	21	19
20	Maketing Sick 70% Disallowed		21	20
21	Marketing Vacation 70% Disallowed	(1,726)	21	21
22	Marketing Overtime 70% Disallowed	(388)	21	22
23	Marketing Non Worked Wages		21	23
24	Donations/ Contributions		21	24
25	Legal Fees - Bankrupcty		21	25
26	Legal Structure Management Fees	(372,247)	21	26
27	Travel Adjustmnt undocumneated		24	27
28	Interest Income		32	28
29	Rent Averaging	(124,281)	34	29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(564,402)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Westchester Health & Rehabilitation # 0047373 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	66	0	0	0	0	0	0	0	0	0	66	5
6	Maintenance	0	259	0	0	0	0	0	0	0	0	0	259	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	325	0	0	0	0	0	0	0	0	0	325	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	15,001	0	0	0	0	0	0	0	0	0	15,001	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	15,001	0	0	0	0	0	0	0	0	0	15,001	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(4,909)	1,347	0	0	0	0	0	0	0	0	0	(3,562)	20
21	Clerical & General Office Expenses	(605,598)	292,549	0	0	0	0	0	0	0	0	0	(313,049)	21
22	Employee Benefits & Payroll Taxes	(41)	0	0	0	0	0	0	0	0	0	0	(41)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(17)	19,375	0	0	0	0	0	0	0	0	0	19,358	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(610,565)	313,271	0	0	0	0	0	0	0	0	0	(297,294)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(610,565)	328,597	0	0	0	0	0	0	0	0	0	(281,968)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Westchester Health & Rehabilitation # 0047373 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	(21,694)	1,633	0	0	0	0	0	0	0	0	0	(20,061)	33
34	Rent-Facility & Grounds	(124,281)	36	0	0	0	0	0	0	0	0	0	(124,245)	34
35	Rent-Equipment & Vehicles	0	15,943	0	0	0	0	0	0	0	0	0	15,943	35
36	Other (specify):*	0	20,376	0	0	0	0	0	0	0	0	0	20,376	36
37	**TOTAL Ownership**	(145,975)	37,988	0	0	0	0	0	0	0	0	0	(107,987)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	(70)	0	0	0	0	0	0	0	0	0	0	(70)	38
39	Ancillary Service Centers	0	31,950	0	0	0	0	0	0	0	0	0	31,950	39
40	Barber and Beauty Shops	200	0	0	0	0	0	0	0	0	0	0	200	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	130	31,950	0	0	0	0	0	0	0	0	0	32,080	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(756,410)	398,535	0	0	0	0	0	0	0	0	0	(357,875)	45

Facility Name & ID Number Westchester Health & Rehabilitation # 0047373 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SSC Equity Holdings LLC	100	See Attachment 6.1		SSC Equity Holdings, I	Atlanta, GA	Management

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	Utilities	$	SSC Equity Holdings LLC	100.00%	$ 66	$ 66	1
2	V	6	Repair & Maintenance		SSC Equity Holdings LLC	100.00%	259	259	2
3	V	39	Professional Services		SSC Equity Holdings LLC	100.00%	31,950	31,950	3
4	V	20	Fees, Subscriptions, Promotions		SSC Equity Holdings LLC	100.00%	1,347	1,347	4
5	V	10	Nursing & Medical Records		SSC Equity Holdings LLC	100.00%	15,001	15,001	5
6	V	21	Clerical & General Office Exp		SSC Equity Holdings LLC	100.00%	292,549	292,549	6
7	V	24	Travel & Seminar		SSC Equity Holdings LLC	100.00%	19,375	19,375	7
8	V	26	Insurance Premium		SSC Equity Holdings LLC	100.00%			8
9	V	36	Depreciation		SSC Equity Holdings LLC	100.00%	20,376	20,376	9
10	V	33	Taxes - Property		SSC Equity Holdings LLC	100.00%	1,633	1,633	10
11	V	35	Rental & Leasing		SSC Equity Holdings LLC	100.00%	15,943	15,943	11
12	V	34	Leasse Expense		SSC Equity Holdings LLC	100.00%	36	36	12
13	V	26	Property Insurance		SSC Equity Holdings LLC	100.00%			13
14	Total			$			$ 398,535	$ * 398,535	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Related Illinois Nursing Homes as of 12/31/2005

Group Name	Related Illinois Nursing Homes	Illinois Facility Number
SSC Equity Holdings LLC		
	Montebello Healthcare Center	0031468
	Nature Trail HealthCare Center	0039586
	Odin HealthCare Center	0039503
	Mariner Health of Westchester	0042374

Facility Name & ID Number Westchester Health & Rehabilitation # 0047373 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Westchester Health & Rehabilitation # 0047373 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: SSC Equity Holdings, LLC
Street Address: One Ravinia Dr. Suite 1400
City / State / Zip Code: Atlanta, GA 30346
Phone Number: ((770) 829-5100
Fax Number: ((770) 393-8054

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities		1		$ 66	$	1	$ 66	1
2	6	Repair & Maintenance		1		259		1	259	2
3	39	Professional Services		1		31,950		1	31,950	3
4	20	Fees, Subscriptions, Promotions		1		1,347		1	1,347	4
5	10	Nursing & Medical Records		1		15,001		1	15,001	5
6	21	Clerical & General Office Exp		1		292,549		1	292,549	6
7	24	Travel & Seminar		1		19,375		1	19,375	7
8	26	Insurance Premium		1				1	0	8
9	36	Depreciation		1		20,376		1	20,376	9
10	33	Taxes - Property		1		1,633		1	1,633	10
11	35	Rental & Leasing		1		15,943		1	15,943	11
12	34	Leasse Expense		1		36		1	36	12
13	26	Property Insurance		1				1	0	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 398,535	$		$ 398,535	25

Facility Name & ID Number Westchester Health & Rehabilitation # 0047373 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Westchester Health & Rehabilitation # 0047373 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2004 report.	***Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 293,326	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 266,504	2
3. Under or (over) accrual (line 2 minus line 1).		$ (26,822)	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 35,532	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 8,710	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2000	245,247	8
2001	250,851	9
2002	272,141	10
2003	254,429	11
2004	266,504	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Westchester Health & Rehabilitation COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0047373

CONTACT PERSON REGARDING THIS REPORT Lee Grigsby

TELEPHONE 832-467-6244 FAX #: 832-467-6246

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	15-29-300-018-0000	2901 S Wolf Rd. Westchester	$ 133,252.11	$ 133,252.11
2.	15-29-300-018-0000	2901 S Wolf Rd. Westchester	$ 133,252.11	$ 133,252.11
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 266,504.22	$ 266,504.22

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number Westchester Health & Rehabilitation # 0047373 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 37,531 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1989	$ 795,000	1
2					2
3	TOTALS			$ 795,000	3

Facility Name & ID Number Westchester Health & Rehabilitation # 0047373 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	160		1989	1989	$ 4,412,330	$ 110,308	40	$ 110,308	$	$ 1,103,081	4
5			1991	1991	217,404	5,435	40	5,435		54,350	5
6			1993	1993	15,459	386	40	386		3,861	6
7			1994	1994	14,498	1,216	40	1,216		12,159	7
8			1995	1995	2,902	73	40	73		729	8
	Improvement Type**										
9	Tile			1996	2,092	53	40	53		492	9
10	Caparting			1996	2,118	(128)	7	(128)		1,990	10
11	Drywall			1996	1,200	30	40	30		294	11
12	Building IMP/APCO			1996	4,439	111	40	111		1,073	12
13	Booster Heater Upgrade			1996	2,810	(232)	7	(232)		2,578	13
14	Repair of washer			1996	1,671	(101)	7	(101)		1,570	14
15	Plumbing Repair			1996	5,328	(150)	7	(150)		5,178	15
16	Healthcare Design			1997	6,896	172	40	172		1,420	16
17	Wallcoverings			1997	55,860	1,395	40	1,395		11,377	17
18	Draperies			1997	66,932	7,003	7	7,003		73,935	18
19	Painting & Decorating			1997	14,813	372	40	372		3,036	19
20	Carpeting			1997	38,524	5,505	7	5,505		45,396	20
21	Building Unterior Design - Nrsng & Therapy Rooms			1997	50,274	1,257	40	1,257		10,371	21
22	Phone System			1998	33,091	(4,963)	5	(4,963)		28,128	22
23	Building Unterior Design - Nrsng & Therapy Rooms			1998	52,903	1,323	40	1,323		10,180	23
24	Construction & Renovation - Nrsing & Therapy Rooms			1998	139,140	349	40	349		18,239	24
25	Heat Air Units			1998	2,239	320	7	320		2,533	25
26	Heat Air Units			1998	1,120	160	7	160		1,267	26
27	Window Treatments			1998	1,518	217	7	217		1,664	27
28	Cubicle Curtains			1998	1,180	169	7	169		1,225	28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Westchester Health & Rehabilitation # 0047373 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Heat Exchange Install	1999	$ 748	$ 19	40	$ 19	$	$ 729	37
38	Heat Exchange Install	1999	6,223	156	40	156		6,068	38
39	Interior Design Serv	1999	150	4	40	4		147	39
40	Flooring -Dining Room #420 & 421	2000	1,065	106	10	106		603	40
41	Flooring -Resident Rooms #422 & 423	2000	2,127	213	10	213		1,206	41
42	Vinyl Tile Resident #426	2000	4,004	400	10	400		2,269	42
43	Vinyl Tile Dining #427	2000	2,064	206	10	206		1,169	43
44	Vinyl Flooring # 432	2000	1,136	227	5	227		1,192	44
45	VCT W/ Wallbase #437	2000	2,650	265	10	265		1,391	45
46	Zone Air HVAC Unit, PT Rm 225 #441	2001	1,850	123	15	123		627	46
47	3: Zoneline HVAC Units #442	2001	5,700	380	15	380		1,868	47
48	3: A/C Compressor, RM 16A,& B, Rm 17A # 445	2001	5,700	380	15	380		1,742	48
49	Rooftop Condenser Coil- Kitchen #446	2001	3,880	259	15	259		1,143	49
50	Rpr Compressor, Leaks -F/A System # 447	2001	3,800	380	10	380		1,647	50
51	Roof Repair - Kitchen & Rm 226 #448	2001	833	83	10	83		361	51
52									52
53	Replc Transfer Switch/Generator #462	2002	3,100	155	20	155		594	53
54	Restore/ Clean Concrete Ramps #5003	2002	3,650	177	15	177		663	54
55	Zoneline Heat/Cool Unit & Use Tax #5009 & 5010	2002	759	152	5	152		531	55
56	A.O. Smith Water Heater -Instl #5017	2002	5,800	580	10	580		1,982	56
57	Compressor Repr -A/C #5020	2002	2,837	189	15	189		663	57
58	12: Door Closers Instl #5027	2002	4,605	307	15	307		1,049	58
59	R Carpet w/Tile (1/3 Deposit) #5032	2002	12,526	1,253	10	1,253		4,280	59
60	Roof Rep (Bal Due) #5035	2002	4,388	439	10	439		1,792	60
61	Vinyl Tile Entry Corridor (25% pmt) #5040	2002	7,000	700	10	700		2,217	61
62	Floor tile Instl -corridor (2nd pmt) #5042	2002	11,000	1,100	10	1,100		3,483	62
63	Credit - W/G Equipment #5043	2002	(250)	(25)	10	(25)		(79)	63
64	2: Repeaters # 5044	2002	1,125	112	10	112		361	64
65	Credit - W/G Discount #5045	2002	(173)	(17)	10	(17)		(53)	65
66	Wanderguard system Instl #5046	2002	46,819	4,682	10	4,682		14,826	66
67	Tile Flooring (pmt #3) #5047	2002	5,000	500	10	500		1,542	67
68	Flooring Project (Final Pmt)	2002	3,304	358	10	358		716	68
69									69
70	TOTAL (lines 4 thru 69)		$ 5,300,158	$ 144,142		$ 144,142	$	$ 1,452,855	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Westchester Health & Rehabilitation # 0047373 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 5,300,158	$ 144,142		$ 144,142	$	$ 1,452,855	1
2	Rprs fire Sprinkler -Atic # 5048	2003	4,300	172	25	172		487	2
3	Sprinkler System Rplc Accelerator # 5054	2003	20,200	808	25	808		2,155	3
4	6: Sleeve/Grille -PTAC Unit #5055	2003	571	114	5	114		285	4
5	6: PTAC Units # 5056	2003	3,261	652	5	652		1,630	5
6	Use Tax 6: PTAC Units # 5057	2003	23	5	5	5		12	6
7	Rplc Shingle Roof # 5058	2003	166,000	16,600	10	16,600		40,117	7
8	Rplc Shingle Roof # 5059	2003	46,900	4,690	10	4,690		11,334	8
9	New Split A/C Syst -Admn Office # 5065	2003	21,500	2,150	10	2,150		5,375	9
10	Rpr Freezer #5068	2003	2,744	183	15	183		412	10
11	Rpr Furnace (service Value core) # 5069	2003	2,131	213	10	213		533	11
12	R Condenser Unit Admin office #5070	2003	2,200	147	15	147		355	12
13	HVAC Repair #5071	2003	4,246	283	15	283		684	13
14									14
15									15
16	RM Oxygen Room	2004	12,457	830	15	830		1,660	16
17	13:thru Wall A/C Units	2004	7,609	888	5	888		1,776	17
18	13:Instl Charge Only A/C Units	2004	4,120	206	10	206		412	18
19									19
20	Instl Door w/Closer, Exit Devic	2005	2,680	74	15	74		74	20
21	Dry Sprinkler System Repair	2005	2,218	44	25	44		44	21
22	Rpr Dry Sprinkler Syst	2005	1,938	32	25	32		32	22
23	Heat Pump	2005	1,305	36	15	36		36	23
24	Double Swing Gate-Dumpsterl	2005	1,308	55	8	55		55	24
25	Heat Shower Room	2005	20,876	696	10	696		696	25
26	Concrete Sidewalk-1/3 Downpayment	2005	1,628	54	15	54		54	26
27	Concrete Sidewalk	2005	3,389	75	15	75		75	27
28	Plumbing Project	2005	4,750	139	20	139		139	28
29	"R" "C" Rev Use Tax	2005	368		20				29
30	Plumbing Repairs	2005	10,000	292	20	292		292	30
31	Instl Door w/Closer, Exit Devic	2005	2,576	43	15	43		43	31
32	Dry Sprinkler System Repair	2005	2,159	22	25	22		22	32
33	Rpr Dry Sprinkler Syst	2005	1,893	19	25	19		19	33
34	TOTAL (lines 1 thru 33)		$ 5,655,510	$ 173,664		$ 173,663	$	$ 1,521,663	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Westchester Health & Rehabilitation # 0047373 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 5,655,510	$ 173,664		$ 173,663	$ (1)	$ 1,521,663	1
2	Heat Pump	2005	1,255	21	15	21		21	2
3	Double Swing Gate-Dumpster	2005	1,226	38	8	38		38	3
4	Heat Shower Room	2005	19,832	496	10	496		496	4
5									5
6	New Furnace 14-B Area	2004	5,690	284	15	284		5,406	6
7	New Furnace 14-A & 11 Area	2004	8,990	449	15	449		8,541	7
8	Evaporator Coil/Consensing Unit	2004	15,989	977	15	977		15,012	8
9	Asphalt-N Driveway	2004	23,550	2,208	8	2,208		21,342	9
10	"R" "C" Sold to SMV	2004	2,809	258	15	258		2,552	10
11	"R" "C" Sold to SMV	2004	3,158	263	10	263		2,895	11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,738,009	$ 178,658		$ 178,657	$ (1)	$ 1,577,965	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Westchester Health & Rehabilitation # 0047373 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,163,284	$ 79,090	$ 79,090	$		$ 842,772	71
72	Current Year Purchases	13,870	1,059	1,059	0		1,059	72
73	Fully Depreciated Assets	(375,502)						73
74								74
75	TOTALS	$ 801,652	$ 80,149	$ 80,149	$ 0		$ 843,831	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 7,334,661	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 258,806	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 258,806	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (0)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,421,796	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Westchester Health & Rehabilitation # 0047373 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: SSC Westchester Operating Company, LLC
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	N/A	120	01/01/2005	$ 623,154	20		3
4	Additions							4
5								5
6								6
7	TOTAL		120		$ 623,154 **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [X] NO Terms: *

10. Effective dates of current rental agreement:
Beginning 01/01/2005
Ending 12/31/2024

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [X] YES [ ] NO
16. Rental Amount for movable equipment: $ 13,712 Description: Copiers and Postage Machine See Attachment 14.1
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	N/A		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SUPPLEMENTAL SCHEDULE - Page 14 -B -16 - EQUIPMENT -RENTAL MOVABLE

Name of G/L	G/L #	EQUIPMENT	Amount		Page/Line/Col Ref From
Lease Exp - Eqpt - Nonmedical <> Default <> NonCert	841000000001011	Specialty Mattress	7,418.00		03/10/03
Lease Exp - Eqpt - <> Default <> Equip Rental	841000000002102				03/10/03
Lease Exp - Eqpt - Nonmedical <> Default <> Activities	841000000007000				03/11/03
Lease Exp - Eqpt - Nonmedical <> Default <> Dietary	841000000007030	Diswasher	280.00		03/01/03
Lease Exp - Eqpt - Nonmedical <> Default <> Housekeepin	841000000007040				03/03/03
Lease Exp - Eqpt - Nonmedical <> Default <> Laundry	841000000007050				03/04/03
Lease Exp - Eqpt - Nonmedical <> Default <> Nursing Admi	841000000008000	Mattress			03/10/03
Lease Exp - Eqpt - Nonmedical <> Default <> Administrative	841000000008100	Copiers, Stamp machine Cable	6,014.00		03/21/03
Lease Exp - Eqpt - Nonmedical <> Default <> Physical Plan	841000000008210				03/05/03
Lease Exp - Eqpt - Nonmedical <> Default <> Realty	841000000008220	Parking Lot			04/35/03
Lease Exp - Other <> Default <> Administrative	841020000008100				03/21/03
			13,712.00		Grand Total

Facility Name & ID Number Westchester Health & Rehabilitation # 0047373 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Westchester Health & Rehabilitation # 0047373 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service		Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a-03	4461	hrs	$ 129,287		$	$	4,461	$ 129,287	1
2	Licensed Speech and Language Development Therapist	10a-03	663	hrs	22,696				663	22,696	2
3	Licensed Recreational Therapist	10a-03		hrs							3
4	Licensed Physical Therapist	39-03	6106	hrs	168,030				6,106	168,030	4
5	Physician Care	39-03		visits							5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy			# of prescrpts				69,182		69,182	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Exceptional Care Program										12
13	Other (specify):										13
14	TOTAL				$ 320,013		$	$ 69,182	11,230	$ 389,195	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number Westchester Health & Rehabilitation # 0047373 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2005 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 300	$	1
2	Cash-Patient Deposits	30,138		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	306,766		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	1,168		6
7	Other Prepaid Expenses	204,013		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 542,385	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	63,883		15
16	Equipment, at Historical Cost	24,142		16
17	Accumulated Depreciation (book methods)	(3,271)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Lease Hold Rights	61,755		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 146,509	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 688,894	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 267,586	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	193,458		30
31	Accrued Taxes Payable (excluding real estate taxes)	31,402		31
32	Accrued Real Estate Taxes(Sch.IX-B)	8,710		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attatchment 17.1	(342,290)		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 158,866	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attatchment 17.1	5,882,289		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 5,882,289	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,041,155	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (5,352,261)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 688,894	$	48

***(See instructions.)**

STATE OF ILLINOIS

Report Period: **Beginning:** 1/1/2005 **Ending:** 12/31/2005

Facility Name & ID Number **Westchester** **#** 42374

SUPPLEMENATAL SCHEDULE OF ASSETS & LIABILITIES

OTHER CURRENT ASSETS:	AMOUNT
Total	0
Reconcile with schedule XV, line 9:	0
Difference	0

OTHER CURRENT LIABILITIES:	AMOUNT
Misc Dedctns - Employee <> Other Decductions <> Default	3,205
Accruals - Insurance <> Accrue HMO Ins <> Default	(1)
Accruals - Insurance <> Self Funded Ins Accr <> Default	37,447
Accruals - Insurance <> Basic Life <> Default	1,039
Accruals - Insurance <> Lt Dsblty <> Default	206
Accruals - Insurance <> Executive Supp Life <> Default	246
Accruals - Insurance <> Short Term Disability <> Default	1,031
Accruals - Insurance <> Dependent Life <> Default-Dept	12
Accruals - Insurance <> Accidental Death Dismemberment <> Default-Dept	27
Accruals - Insurance <> NES Insurance <> Default-Dept	558
Accrued Other <> Default	152,800
Accrued Other-Default-Dept-Suspense Allocation	145,719
Total	342,289
Reconcile with schedule XV, line 36:	342,289
Difference	-

OTHER NON-CURRENT ASSETS:	
Excess Reorganized Value <>Excess Reorg Value <> Default	
Other Assets <> Rfndable Deposits-Non Int Brg <> Default	
Total	-
Reconcile with schedule XV, line 23:	0
Difference	-

OTHER NON-CURRENT LIABILITIES::	
I/C - Interunit Asset Transfer-Default-Dept-Default-Prod	493,939
Intercompany - Revolver <> Default <> Default	4,948,272
Intercompany Revolver - SSC-Default-Dept-Default-Prod	19,780
L/T Benefits Reserve-Default-Dept-PLGL Post-Petition Claims	285,661
Other Non-Current Lby <> Rent Accrual <> Default	134,637
Total	5,882,289
Reconcile with schedule XV, line 43:	5,882,289
Difference	0

Facility Name & ID Number Westchester Health & Rehabilitation **#** 0047373 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,717,286	1
2	Restatements (describe):		2
3	**Asset Transfer**	3,283,255	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 5,000,541	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	351,720	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 351,720	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 5,352,261	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Westchester Health & Rehabilitation # 0047373 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,786,337	1
2	Discounts and Allowances for all Levels	(3,664,640)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,121,697	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,242,606	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,242,606	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	28,745	13
14	Non-Patient Meals	951	14
15	Telephone, Television and Radio	11,282	15
16	Rental of Facility Space		16
17	Sale of Drugs	721,764	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	67,539	19
20	Radiology and X-Ray	24,150	20
21	Other Medical Services	264,599	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,119,030	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc Receipts (See Schd pg 19.1)	4,268	28
28a	Misc Receipts Vending (See Schd pg 19.1)	398	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 4,666	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,487,999	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	960,455	31
32	Health Care	3,100,183	32
33	General Administration	1,944,924	33
	B. Capital Expense		
34	Ownership	1,016,619	34
	C. Ancillary Expense		
35	Special Cost Centers	48,398	35
36	Provider Participation Fee	65,700	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,136,279	40
41	**Income before Income Taxes (line 30 minus line 40)****	351,720	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 351,720	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

SUPPLEMENATAL INCOME SCHEDULE

DESCRIPTION	AMOUNT
Miscellaneous Receipts<>Default<>Prod<>Administrative	4,268

	Total	4,268.00	Difference
Reconcile with schedule XVII, line 28:		4,268	0

DESCRIPTION	AMOUNT
Miscellaneous Receipts<>Default<>Prod<>Vending	398

	Total	398	Difference
Reconcile with schedule XVII, line 28a:		398	-

Facility Name & ID Number Westchester Health & Rehabilitation # 0047373 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	5,552	5,558	$ 202,763	$ 36.48	1
2	Assistant Director of Nursing					2
3	Registered Nurses	19,316	19,336	543,660	28.12	3
4	Licensed Practical Nurses	16,301	16,318	428,685	26.27	4
5	CNAs & Orderlies	72,736	72,808	882,514	12.12	5
6	CNA Trainees					6
7	Licensed Therapist	5,402	5,541	140,736	25.40	7
8	Rehab/Therapy Aides	6,213	6,373	208,027	32.64	8
9	Activity Director	1,905	1,928	30,305	15.72	9
10	Activity Assistants	3,941	3,987	41,909	10.51	10
11	Social Service Workers	2,355	2,361	53,246	22.55	11
12	Dietician					12
13	Food Service Supervisor	2,032	2,031	45,963	22.63	13
14	Head Cook	6,187	6,190	81,232	13.12	14
15	Cook Helpers/Assistants	14,741	14,750	120,650	8.18	15
16	Dishwashers					16
17	Maintenance Workers	4,516	4,516	72,095	15.96	17
18	Housekeepers	12,982	13,005	118,250	9.09	18
19	Laundry	6,099	6,099	62,780	10.29	19
20	Administrator	2,571	2,608	90,690	34.77	20
21	Assistant Administrator					21
22	Other Administrative	1,836	1,863	44,740	24.02	22
23	Office Manager					23
24	Clerical	11,976	12,147	170,899	14.07	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,025	1,025	14,250	13.90	31
32	Other Health C: Medicare Cord.-C:	3,018	3,018	74,408	24.65	32
33	Other(specify) Mktg & Transpota	2,069	2,069	52,964	25.60	33
34	TOTAL (lines 1 - 33)	202,773	203,531	$ 3,480,766 *	$ 17.10	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	581	$ 23,254		35
36	Medical Director	86	14,400		36
37	Medical Records Consultant	98	4,224		37
38	Nurse Consultant	309	15,001		38
39	Pharmacist Consultant	89	3,819		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	129	7,090		44
45	Social Service Consultant	42	2,307		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,334	$ 70,096		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Westchester Health & Rehabilitation # 0047373 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Edward Brazil	Administrator		$ 4,623
Sandra Gourley	Administrator		59,949
Connie Trunk	Administrator		16,231
Linda Morefield	Administrator		5,098
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 85,901

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 183,402
Unemployment Compensation Insurance	144,904
FICA Taxes	255,511
Employee Health Insurance	84,522
Employee Meals	41
Illinois Municipal Retirement Fund (IMRF)*	
Pension/ Retirment	88
Insurance Life	4,472
Other Benefits	6,660
TOTAL (agree to Schedule V, line 22, col.8)	$ 679,600

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	57,664
Health Care Worker Background Check	
(Indicate # of checks performed)	1,840
Other Licenses Fees	2,278
Dues	6,730
Rounding	
Home Office	1,347
Total Advertising	9,127
Less: Public Relations Expense	( )
Non-allowable advertising	(4,909)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 74,077

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 15,131
In-State Travel	223
Seminar Expense	3,007
Home Office	19,375
Entertainment Expense	(17)
TOTAL (agree to Sch. V, line 24, col. 8)	$ 37,719

**See instructions.

Facility Name & ID Number Westchester Health & Rehabilitation # 0047373 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Westchester Health & Rehabilitation # 0047373 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Healthcare Association $6,288.00**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **66,463** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **65,700**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **41** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **41**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **Yes**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **N/A**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees